Phone (732) 353-6335
Fax (732) 254-1533
to talk to the people who care about you

East Brunswick Physical Therapy, LLC

Williamsburg Commons
3-A & B Auer Court
East Brunswick, NJ 08816

PATIENT INFORMATION

Please complete all of the following information thoroughly:

Name: _____
Last, First Middle Occupation

Address: _____
Street/PO Box City State Zip

Residence if different from above: _____
Street/PO Box City State Zip

( )_____ ( ) _____ ( ) _____
Home Phone Work Phone Cell Phone

_____
Date of Birth Age Sex Social Security# Email Address

_____
Nearest Relative / Emergency Contact Phone # How did you hear about us?

Work Information: _____
Name Address Phone

Referring Physician: _____
Name Phone

If Party is a minor: _____
Name of Insured Parent Social of Insured Parent DOB

Diagnosis: _____ Date of Injury _____

Circle YES or NO

1. Is this condition related to an injury on the job? Yes No
   If Yes, please provide workers compensation information below
2. Is this injury related to a Motor Vehicle Accident? Yes No
   If yes, please provide your auto Insurance Information below
3. Is this injury involved or will be Involved In litigation? Yes No
   If yes, phase provide attorney information below

Yes answers: _____

_____

I authorize East Brunswick PT to release and request information to/from Insurance companies and all medical providers.
I authorize assignment of benefits directly to this clinic.

Parent or Guardian Signature _____ Date _____

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INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by the use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities, and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person, hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. East Brunswick Physical Therapy does not guarantee what your reaction will be to a Specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeing treatment for, Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with your treating physical therapist throughout your treatment.

It is your right to decline any pan of your treatment at any time before or during treatment, should you feel any discord fort or pain or have other unresolved concerns. It is your right to ask your physical therapist about†he treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential asks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care, I authorize the release of my medical information to appropriate third parties.

Patient Name: _____ Signature: _____ Date: _____

Patient Acknowledgment Form

Notice of Privacy Practices

I have been provided with a copy of East Brunswick Physical Therapy's Notice of Privacy Practices, which describes East Brunswick Physical Therapy's use and disclosure of my Protected Health Information. (PHI)

Patient Name: _____

Patient Signature: _____

Date: _____

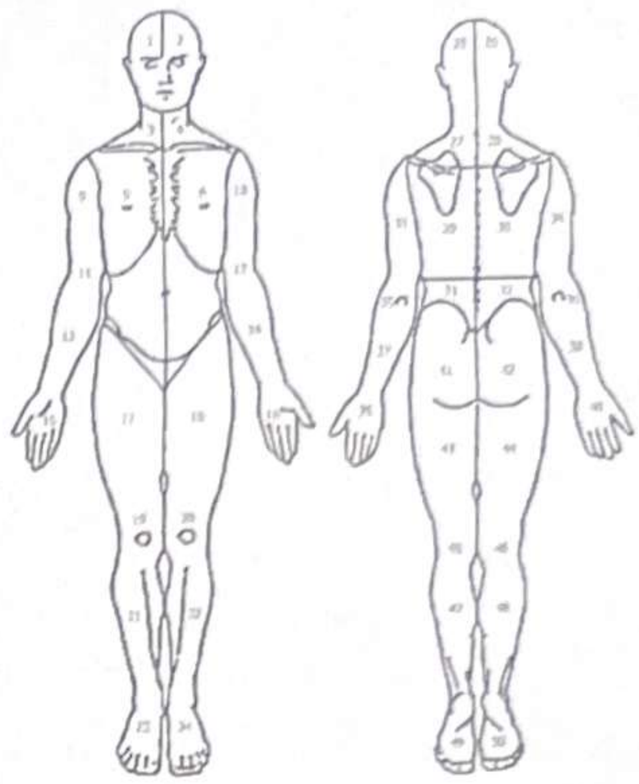
Past Medical History Form

If you are having pain, please circle the best indication on a 0-10 scale, where 0 is no pain and 10 is the most severe pain:

At worst: *0 1 2 3 4 5 6 7 8 9 10*

Current: *0 1 2 3 4 5 6 7 8 9 10*

At Best: *0 1 2 3 4 5 6 7 8 9 10*



Please indicate the location of your symptoms above by circling the area.

Pain description (please circle):

Burning Aching Shooting Sharp

Please place a (X) if you have experienced or currently have any of the following:

Cancer ( )

Pacemaker ( )

Diabetes ( )

Cardiac Conditions ( )

Pregnant ( )

Stroke/TIA ( )

Osteoporosis ( )

Loss of Bowel/Bladder control ( )

Falls within the last year ( )

Please List any necessary information related to the topics below:

Medications:_____

_____

Prior Surgeries:_____

_____

Allergies:_____

_____

*Patient/Guardian Signature:*_____ *Date:*_____

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ASSIGNMENT OF BENEFITS

Policy# _____

Patient's Name _____

I authorize and request _____ insurance company to pay directly to the above named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by the medical provider and all medical staff associated with the provider's office.

Patient's Signature or Parent/Legal Guardian _____ Date _____

Provider's Signature _____ Date _____